Saint Francis Memorial Hospital
A member of CHW

MISSED REST/MEAL BREAK INCIDENTAL OVERTIME/DOUBLE-TIME REPORT

Please complete whenever a break is missed or incidental premium pay is requested. Submit to department Director to ensure proper and timely staff payment and tracking. Reasons must be included and all requests must be verified as noted.

NAME:_____ **UNIT:**_____

DATE:_____ **SHIFT:**_____

Break(s) Missed:

Meal _____ _____
Scheduled Time — Verification *(Supervisor, Lead or Charge Nurse)*

Rest _____ _____
Scheduled Time — Verification *(Supervisor, Lead or Charge Nurse)*

Rest _____ _____
Scheduled Time — Verification *(Supervisor, Lead or Charge Nurse)*

Incidental Overtime/Double-time

Minutes _____ _____
Total — Verification *(Supervisor, Lead or Charge Nurse)*

Reason for missed break: _____

_____

Reason for incidental overtime/double-time: _____

_____

How can missed breaks or incidental overtime/double-time be avoided in the future? _____

_____

_____

Manager/Director/Supervisor Signature: _____